Choices for Care - Case Management, Respite & Companion Services CFC 813A 2/2016

Variance Request Form

- **Instructions**: Case Management, Respite, and Companion services all have a maximum allowed number of hours per calendar year. Complete this form for **individuals** who require additional hours and meet the variance criteria. Send the request to the contact noted at the bottom of the form. Requests will be reviewed by the Adult Services Division (ASD) at the Disabilities, Aging & Independent Living (DAIL) . A new Service Plan is not required. *One request per form please*.

- **Variance Criteria:** A variance will only be approved in situations in which the additional services are necessary to protect or maintain the health, safety or welfare of the individual. (*See CFC Regulations, Section XI.*)

- **Retroactive Requests**: Approved variances are effective no earlier than the date the request was received at DAIL/Adult Services Division. Retroactive requests will be considered only when a precipitating event necessitated an immediate increase of services exceeding the currently approved volume of services. The immediate increase must be necessary to prevent harm to the individual, a hospitalization or nursing facility placement.

NOTE: Prior to approval, DAIL may request additional information including case notes as needed.

Completed by Case Manager:

Program (check one): ☐ Moderate Needs ☐ High/Highest

Service (check one) ☐ Case Management ☐ Respite (High/Highest Only) ☐ Companion (High/Highest only)

1. Individual's Name: _____
2. Date of Birth: _____
3. Social Security Number: _____
4. Hours currently authorized: _____
5. Hours used as of the date of this request: _____
6. Additional hours being requested: _____
7. Requested Start Date: _____

8. Describe the consumer's unmet needs that require additional hours.

9. Describe the services that will be provided if the request is granted. For case management include actual tasks to be delivered to the individual.

10. Describe what other options have been explored (such as informal supports, Adult Day, consultation with Division for Blind and Visually Impaired, etc.).

11. If a **retroactive start date** is being requested, explain the precipitating event that necessitated an immediate increase of services exceeding the currently approved volume of services. Include the date of the event and explain why the delay of request.

Case Manager's name: _____

Agency: _____ Phone number: _____

Signature: _____ Date: _____

***Mail request to*:**
Choices for Care Program, DAIL
280 State St. HC 2 South
Waterbury, VT 05671-2070 **or**
Fax: Moderate Needs Forms: to 802-828-0613 **High/Highest Forms:** to (802) 241-0385

ASD Team Decision: ☐ Approve ☐ Deny ☐ Partial Approval ***Hours approved in this request:*** _____

Total Hours for Calendar Year: _____ ***Effective Date:*** _____ ***Retroactive?*** ☐ Yes or ☐ No

LTCCC*:** _____ ***Prior Authorization needed? ☐ Yes or ☐ No
Copy to ARIS: ☐ Yes or ☐ No
Comments:

DAIL Authorized Signature: _____ **Date:** _____